January 23, 2019

Dear Susana Mendoza,

As mayor of Chicago, you would be responsible for the fair and equitable enforcement of ordinances for all residents of our city. As such, we have created a questionnaire to gather your opinions on a range of drug policy initiatives to reduce drug overdose fatalities and other drug-related harms in the city.

Drug overdose is now the leading cause of accidental death in the United States.[1] This crisis has not spared our city. The latest available data show an increase in opioid-related overdose fatalities from 285 in 2014[2], to 796 by 2017.[3] Chicago's fatal opioid overdose rate is higher than the national rate, and nearly double national rate for Black/African American Chicagoans.[4] In comparison, the number of homicides in Chicago in 2017 was 659.[5]

The City of Chicago can and should do more to implement and support drug policy measures that have been proven to save lives.

As community members, individuals with lived experience, and professionals who support evidence-based approaches to drug use, we recognize that all societies consume drugs and that our work should aim to reduce negative outcomes. For this reason, we advocate for research-supported interventions such as syringe exchange, overdose prevention centers, and universal access to the life-saving overdose reversal medication naloxone. Furthermore, given the mass incarceration produced by our nation's War on Drugs combined with the well-demonstrated fact that drug enforcement has severely and disproportionately compromised the health of Black and Latino communities, we support the decriminalization of all drugs as well as a reinvestment in Black and Latino-led organizations.

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[1] American Society of Addiction Medicine. (2016). *Opioid addiction 2016 facts and figures*. Retrieved from https://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf

[2]Illinois Department of Public Health. (2017). *Drug Overdose Deaths by Sex, Age Group, Race/Ethnicity, and County, Illinois Residents 2013-2016*. Retrieved from http://www.dph.illinois.gov/sites/default/files/publications/Drug-Overdose-Deaths-March-2017-031617.pdf

[3] Rushovich, T, Arwady, A., Salisbury-Afshar, E., Arunkumar, P., Kiely, M., Aks, S., Prachand, N. (2018, October). Annual opioid surveillance report – Chicago 2017. Retrieved from https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/ChicagoOpioidReport2018.pdf

[4] Ibid.

[5] Chicago Police Department (2019). Chicago Police Department CompStat. Retrieved from https://home.chicagopolice.org/wp-content/uploads/2019/01/1_PDFsam_CompStat-Public-2018-Week-52.pdf

As Mayor, you would have the opportunity to focus our great city on efforts that increase safety, reduce healthcare costs, and quite literally save lives; we hope your answers to these questions can clarify how you plan to support those efforts.

Please send your responses and any questions to Vilmarie Narloch at vilmarie@ssdp.org.

Please have all responses submitted no later than Wednesday, February 6th by 5 pm.

Both responses -- and non-responses -- will be made available to the public in order for voters to understand your positions on these issues.

Sincerely,

Drug User Health Collective of Chicago
Chicago Recovery Alliance
Chicago Drug Users Union
Students for Sensible Drug Policy
Clergy for a New Drug Policy
Above & Beyond Family Recovery Center
Sex Workers Outreach Project Chicago
Men & Women In Prison Ministries

Illinois 2019 Mayoral Candidate Questionnaire:
Rethinking Drug Policy & Public Health Solutions for Chicago's Overdose Crisis

When answering these questions, please consider how you might approach these issues differently from or similar to the current mayor. We are looking to understand your positions on drug policy and public health.

Expanding Access to Naloxone & Overdose Prevention Education

1. Since August 1996, the Chicago Recovery Alliance (CRA) has been distributing the life-saving overdose reversal medication naloxone directly to individuals best positioned to respond in the event of a fatal overdose, that is people who use drugs (PWUD) as well as friends, family members, and providers of PWUD. Under the Illinois Drug Overdose Prevention Program Law (PA 096-0361, 2010), laypersons are permitted to carry and administer naloxone in the event of an overdose.[6] In 2018, CRA distributed nearly 100,000 doses of naloxone, trained roughly 3300 people, and received reports of more than 1,000 nonmedical, peer-facilitated overdose reversals. Despite the numerous lives saved by naloxone, numerous barriers persist in accessing this life-saving medication in Chicago. Some of these barriers include the prohibitive cost of the medication, lack of training on how to use it, lack of knowledge around overdose risk, not knowing how to access it, and simply not knowing that the antidote exists.

How will you support naloxone distribution and overdose education for the City of Chicago?

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[6] Illinois General Assembly. (2010, January, 1). *Public Act 096-0361*. Retrieved from http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=096-0361

We have long had a serious opioid overdose problem in Chicago—long before the media started paying attention to it a few years ago as suburban populations began feeling the effects. The Chicago Recovery Alliance and other community-based organizations have spent decades doing critical work to reduce overdose deaths. Dan Bigg in particular was a champion of harm reduction before his tragic passing last year. We are lucky to have had him in Chicago and must build on the work he pioneered.

Such work is needed now more than ever. The death toll from heroin, fentanyl, and other opioids is rising fast and now exceeds homicides. A critical part of preventing overdose deaths is naloxone, an evidence-based medication that saves lives by reversing an overdose on the spot. It must be widely understood and accessible across the city—especially among people who use drugs, since this population is more likely than anyone else to see someone overdosing and save a life.

To start, the City must increase its current funding for naloxone distribution. This work, which is being done by the Chicago Recovery Alliance, has been effective at reaching key populations, especially those involved in needle exchanges. We must also invest in reaching populations in other settings, since many users do not inject opioids. These settings may include churches, community centers, and any other locations in which people congregate, especially on the south and west side neighborhoods where overdose deaths are most prevalent. The City has recently funded community health workers to provide naloxone and educate residents about the medication while connecting them to ongoing treatment; this program must be expanded and made sustainable. Providers, too, must be educated so that patients in treatment are offered naloxone. Finally, we must ensure that as police become equipped with naloxone, the effort is implemented effectively and in a way that saves lives while improving police-community relations.

Expanding Access to Medication-Assisted Treatment

2. Medication-Assisted Treatment (MAT), also known as Opioid Substitution Therapy (OST) consists of combining medication and behavioral therapy in order to support individuals with opioid use disorder (OUD) achieve recovery.[7] These evidence-based treatment interventions include FDA-approved medications such as buprenorphine and methadone. When combined with behavioral therapy, these medications are associated with a number of positive outcomes including but not limited to decreased overdose risk, decreased infectious disease transmission, increased positive birth outcomes for women

[7] Substance Abuse and Mental Health Services Administration (SAMHSA). (2015, September, 28). *Medication and counseling treatment*. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

who are pregnant, decreased use of illicit substances, and increased employability.[8] A third FDA-approved medication exists that is known as naltrexone or Vivitrol. Naltrexone is a newer medication and unlike buprenorphine and methadone functions solely as an opioid antagonist and has yet to demonstrate its efficacy in preventing opioid related mortality[9]. For this reason, we do not recommend the use of naltrexone to treat people with OUD. Despite the overwhelming evidence in favor of methadone and buprenorphine, tremendous obstacles stand in the way of people accessing these interventions, not the least of which is stigma and misconceptions about MAT.[10]

How will you support expanded access to MAT?

Medication-assisted treatment (MAT), especially with methadone or buprenorphine, is an evidence-based approach to tackling opioid use disorder. The barriers to access—and the stigma against this practice—must end. No one would think to stigmatize someone for taking medication to treat other health conditions. Substance use disorders should be no different.

The goal of expanded access requires progress at the city, state and federal levels. We must explore alternative delivery models to help foster immediate access, such as through pharmacies and mobile vans. Zoning barriers, too, which are inevitably linked to stigma, must be assessed. The City should also advocate for better reimbursement at the state level to allow providers to offer MAT services at cost, and for recovery homes to accept patients who are on MAT instead of excluding them from services. Other steps the City can take include:

- Offering grants to offset the cost of essential services not covered by Medicaid, such as recovery homes.
- Funding programs at emergency departments to provide SBIRT (screening, brief intervention, and referral to treatment) to all patients while offering naloxone and buprenorphine induction to those who are brought in for an overdose. We could explore adapting models such as those in New Haven and elsewhere.
- Expanding educational work for physicians and other healthcare providers so they obtain waivers to prescribe buprenorphine and, most importantly, integrate it into their practices.
- Expanding funding for community health workers who provide naloxone, educate residents, and link people with opioid use disorder to treatment. This funding must be made sustainable.

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[8] Ibid.
[9] National Institutes of Health. (2018, June 19). *Methadone and buprenorphine reduce risk of death after opioid overdose.* Retrieved from https://www.nih.gov/news-events/news-releases/methadone-buprenorphine-reduce-risk-death-after-opioid-overdose
[10] Ibid.

- Supporting pre-arrest diversion and deflection programs to help more people get treatment instead of a criminal record.

Legalizing Syringe Services Programs

3. Syringe services programs or SSPs (also known as needle/syringe exchange programs or N/SEPs) provide community-level access to sterile syringes as well as safe disposal services for used equipment.[11] SSPs are cost-effective,[12] public health interventions that prevent the spread of infectious diseases such as HIV and hepatitis and reduce the presence of bacterial and other infections often related to injection drug use.[13] These interventions also function as drop-in centers where PWUD can go to get support for other critical needs such as substance use and mental health treatment referrals, housing resources, and STI and hepatitis screening and linkage to care. Despite all the evidence supporting these programs, SSPs remain illegal in the state of Illinois and therefore can only operate via research exemption, thus greatly impeding the full-scale impact of these programs.

How will you support the legalization of sterile syringe access for Chicago as well as statewide? How will you ensure that the City of Chicago continues to publicly fund sterile syringes for distribution?

Syringe exchanges should not have to keep hiding behind the guise of a research exemption. The data is in, and these efforts work. Legislation acknowledging this reality by allowing more robust avenues for syringe exchanges would be a statement against stigma as well as a concrete opportunity for expanding access and advancing harm reduction, beyond what is already occurring. In my administration, the City of Chicago will not backtrack on funding this important work.

Supporting Overdose Prevention Centers

4. An overdose prevention center or OPC (also referred to as safer consumption sites or drug consumption rooms) is a protected location where PWUD can consume their drugs safely under the supervision of trained personnel.[14] OPCs are evidence-based interventions

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[11] Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, & Centers for Disease Control and Prevention. (2018, December 13). Syringe services programs. Retrieved from https://www.cdc.gov/hiv/risk/ssps.html

[12] Frakt, A. (2016, September 2). *Effectiveness and cost-effectiveness of syringe exchange programs*. Retrieved from https://www.academyhealth.org/node/2211

[13] Ibid.

[14] Reynolds, A. (2016, September 27-28). Safer consumption spaces in the United States: Uniting for a national movement. Retrieved from https://www.projectinform.org/wp-content/uploads/2017/06/SCS-Think-Tank-Report.pdf

used to reduce drug overdoses as well as other drug-related harms.[15] These interventions exist in a variety of models such as fixed site, mobile, and temporary pop-up units and have been in operation for over 30 years around the world. More than 100 such sites exist worldwide, and all research indicates significant benefits.[16] They are associated with a decrease in overdose, public drug use, incarceration, drug litter, HIV and Hepatitis C transmission, increased drug treatment admission, and no increase in drug use.[17] While no such program has ever legally existed in the United States, several U.S. cities have declared their support for this intervention[18] and others have secured municipal approval to proceed with opening OPCs in their cities.[19] OPCs have been endorsed by a number of professional bodies including the American Public Health Association,[20] the Law Enforcement Action Partnership,[21] The International Narcotics Control Board,[22] the American Medical Association (AMA),[23] the International Drug Policy Consortium,[24] and the European Monitoring Centre for Drugs and Drug Addiction.[25]

Due to federal drug laws, such sites would ideally be placed on city property.

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[15] Ibid.
[16] Ibid.
[17] European Monitoring Centre for Drugs and Drug Addiction (2017). Drug consumption rooms: an overview of provision and evidence. Retrieved from http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf
[18] Cunningham, P. W. (2018, April 30). The health 202: Supervised injection facilities are illegal in the United States. These cities want to open them anyway. *The Washington Post*. Retrieved from https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/04/30/the-health-202-supervised-injection-facilities-are-illegal-in-the-united-states-these-cities-want-to-open-them-anyway/5ae5dbc630fb043711926901/?noredirect=on&utm_term=.27577cd292ac
[19] Neuman, W. (2018, May 3). De Blasio moves to bring safe injection sites to New York City. *The New York Times*. Retrieved from https://www.nytimes.com/2018/05/03/nyregion/nyc-safe-injection-sites-heroin.html
[20] American Public Health Association. (2013, November 5). *Defining and implementing a public health response to drug use and misuse*. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse
[21] Law Enforcement Action Partnership. (n.d.). *Harm reduction*. Retrieved from https://lawenforcementactionpartnership.org/our-issues/harm-reduction/
[22] The International Narcotics Control Board. (2016). *Report 2016*. Retrieved from https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ChapterIII-Europe.pdf
[23] American Medical Association. (2017, June 12). *AMA wants new approaches to combat synthetic and injectable drugs.* Retrieved from https://www.ama-assn.org/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs
[24] Schatz, E. & Nougier, M. (2012, June). *Drug consumption rooms: Evidence and practice*. Retrieved from https://www.drugsandalcohol.ie/17898/1/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf
[25] European Monitoring Centre for Drugs and Drug Addiction. (2018, June). *Drug consumption rooms: An overview of provision and evidence.* Retrieved from http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf

What will you do to support the creation of a publicly-funded pilot OPC in the City of Chicago?

My administration will embrace the principle of harm reduction. I will also be open to practices that are not commonly employed in the United States but hold the potential to stop overdose deaths—even if the Trump administration opposes them. Overdose prevention centers (OPCs) constitute one such approach that deserves to be explored in Chicago. OPCs may be able to reverse overdoses and draw high-risk populations that can be offered naloxone and treatment. New York, Seattle, Philadelphia, and San Francisco have all committed to opening OPCs or conducting a feasibility study. No site has yet opened, but we must explore every practice that can reduce the city's unacceptably high number of overdose deaths.

Decriminalization

5. We advocate for the decriminalization of all drug use and possession. The War on Drugs has failed to address drug-related harms while having a disproportionate impact on incarceration rates in Black and Latino communities.[26] To that end, we support the elimination of legal penalties for drug-related infractions.[27] A study by the World Health Organization found that countries such as the U.S. that uphold punitive drug laws did not achieve lower levels of drug use amongst their populations when compared to countries with less criminally punitive laws.[28] Several countries and some U.S. municipalities have or are beginning to support a variety of decriminalization measures that recognize substance use as a public health matter rather than a law enforcement one.[29] In 2001, for instance, Portugal simultaneously decriminalized drug use and possession via a reclassification of penalties, while also increasing access to harm reduction and treatment services.[30] This combination of criminal justice reforms coupled with aggressive public health investments reduced drug-related mortality, problematic substance use and arrests, rates of infectious diseases, and also increased drug treatment participation.[31]

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[26] Drug Policy Alliance. (2015, February). *Approaches to decriminalizing drug use and possession.* Retrieved from https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Approaches_to_Decriminalization_Feb2015_1.pdf

[27] Ibid.

[28] Degenhardt L, Chiu W-T, Sampson N, Kessler RC, Anthony JC, et al. (2008) Toward a global view of alcohol, tobacco, cannabis, and cocaine use: Findings from the WHO World Mental Health Surveys. PLoS Med 5(7): e141. doi:10.1371/journal. pmed.0050141

[29] Ibid.

[30] Drug Policy Alliance. (2015, February). *Approaches to decriminalizing drug use and possession.* Retrieved from https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Approaches_to_Decriminalization_Feb2015_1.pdf

[31] Ibid.

What will you do to support decriminalization of all drug consumption and possession city-wide, particularly in communities hardest hit by the War on Drugs? Furthermore, how will you ensure Black and Latino-led organizations are included in all decision making?

The sad reality is that the War on Drugs has racist origins. The prohibition of marijuana was linked to the perception that Mexicans were the ones who used it. The War on Drugs declared by President Nixon capitalized on white fears of minority communities, mainly African American men. To this day, the drug war continues to perpetuate racial disparities. Whites use drugs at about the same rate as black and brown populations but are punished for it less often. We must start to treat drugs more as a public health issue and less as a criminal one. I favor several steps to help Chicago move in that direction:

- Legalize marijuana. Sale and use of cannabis must be regulated and researched to provide for public health and safety, but the time of prohibition of this drug must end.
- Make possession of small amounts of other drugs a misdemeanor.
- Support pre-arrest diversion and deflection programs to help people who use drugs obtain treatment before getting caught up in the criminal justice system.

This approach would help make our criminal justice system more cost-effective and humane while leading to outcomes that are less racially disparate. Allowing law enforcement to focus on other crimes would be fairer to police and communities alike. We must reduce our reliance on police officers as the first line of response to behavioral health issues.

<u>Drug-Induced Homicide</u>

6. Drug-induced homicide laws have been used to criminalize anyone who uses, shares, and/or sells drugs.[32] These laws are often applied when an individual calls 911 for assistance in the event that someone they are with experiences a fatal overdose after using illicit substances. This often results in an arrest of the individual who responds to the life-threatening emergency simply because they had shared drugs with or sold drugs to the individual who overdosed and died. Drug-induced homicide laws only weaken 911 Good Samaritan laws designed to prevent overdose fatalities and persist despite any evidence that they actually reduce drug use or sales.[33] Unfortunately, these laws result in further disengaging PWUD from emergency medical services in the event of an overdose, further exacerbating the risk of death.[34]

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[32] Drug Policy Alliance. (2017, November). An overdose death is not a murder: Why drug-induced homicide laws are counterproductive and inhumane. Retrieved from https://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf

[33] Ibid.

[34] Ibid.

In what ways will you support the elimination of drug-induced homicide laws?

No one who sees someone overdosing should fear legal repercussions if they call 911. Saving a life must be the priority. Yet many people who use drugs will not make the emergency call, knowing there are many loopholes in the Good Samaritan protections. Even social service providers are often reluctant to give a full-throated recommendation to call for emergency assistance. I favor state legislation that closes loopholes in these protections. And while I am strongly opposed to dispensing or dealing drugs, most Chicagoans would agree that neither is the same as homicide, except in the most unusual and egregious of cases. We must bring together healthcare providers, people who use drugs, community members, law enforcement, and experts to develop ways to root out drug trafficking without harming the very populations that need the most help.